MONTHLY DEPENDENT CARE CLAIM FORM

Part 1: Employee Information:

Employee Name: (First) _____ (Last) _____

Social Security Number: _____-_____-_____ Work Phone: _____

Employer Name: City of Torrance E-mail: _____

Part 2: Address Change Section: (Only complete this section if you have had a change in address.)

Address: _____, _____, _____, _____

Part 3: Employee Certification for Reimbursement:

The expenses listed below were incurred by my "dependent(s)" in order for me (and my spouse) to remain gainfully employed or attend school full-time. The expenses incurred are not for tuition or school fees designated for educational purposes. The amount I claim under the Dependent Care Reimbursement may not exceed the maximum calendar year per family of $5,000, or $2,500 if married filing separately. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit (such as the Dependent Care Credit). I agree to file IRS Form 2441 with my tax return and provide any taxpayer identification number required thereon.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature _____ **Date** _____

Part 4: Provider Certification (Only needed if you do not have supporting documentation.)

I certify that we are providing Child Care Services for the above employee for the month of _____ in the year of _____ as shown below.

Provider Signature_____ Date: _____

Dependent Names/Ages _____/____ _____/____

_____/____ _____/____

Name of Provider/Entity_____

Federal Id # or Social Security Number: _____

Part 5: Dates of Service

	Service Date	Amount
Week 1	_____/____/_____ to _____/____/_____	$_____
Week 2	_____/____/_____ to _____/____/_____	$_____
Week 3	_____/____/_____ to _____/____/_____	$_____
Week 4	_____/____/_____ to _____/____/_____	$_____
Week 5	_____/____/_____ to _____/____/_____	$_____
	Total Requested Amount	$_____

Dependent Care Claims are reimbursed to the participant up to the balance available in the account. Incomplete forms will be denied requesting additional information. Account information is available at www.myrsc.com. Please allow 24 to 48 hours after faxing to verify receipt. Customer Service is available 8:00 a.m. to 5:00 p.m., Eastern Standard Time toll free at 800-877-6630. **To set up direct deposit (if applicable) attach a voided check with your first claim.**

FOR QUICKEST REIMBURSEMENT FAX TO 513-326-8082 OR EMAIL 125@SHEAKLEY.COM

Or mail to: Sheakley Flexible Benefits
One Sheakley Way
Cincinnati, OH 45246